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THE LOCAL HEALTH LINK

Stimulating Shorts from Frankfort

Open Letter to KY Public Health Workers, Boards of Health, & Concerned Citizens

- *submitted by Rice C. Leach, MD, Commissioner, Dept of Public Health*

Just about everyone concerned with local health departments knows that there are major changes taking place in the way we receive our funding. These changes have made it necessary to alter the way we do business and are likely to require still more changes as time goes by. Many among us believe that it is only the health departments that are being impacted. That is simply untrue. Kentucky's local health departments are caught up in the same funding changes that are impacting the entire health care system. Just ask your local physician, dentist, pharmacist, or hospital administrator. Many think that these changes are a new phenomenon. That is also an erroneous perception. As a matter of fact, the state and local health departments in Kentucky have been experiencing gradual change in their funding support for several years as a result of a number of factors over which they have little control. Consider the following:

- Federal, state, and local funds to support public health have not kept pace with inflation. This is true for both funds to support core public health activities and for funds to support specific public health programs such as cancer screening.
- State and federal program mandates have not always been fully funded from the outset. This created "unfunded mandates" at the local level.
- Funding for public health has grown significantly over the years; however, this fund growth has been dedicated to program expansions for specific activities rather than general public health.
- Policy decisions related to the environmental health program require user fees to support a significant portion of state environmental activity. The limited fee increases that have been approved do not support the

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requirements created by inflation, program expansion, and required regulatory activity.

- At times, general fund appropriations have been redirected from general public health to support the Medicaid program. Simultaneously, local health departments were authorized to receive cost-based reimbursement for preventive services. This generated significant revenues but it also required staff to become clinic based to see patients and generate revenue.
- Health departments have lost cost-based reimbursement in selected program areas.
- Medicare no longer pays for home nursing visits to collect blood for tests and Medicare has introduced a uniform fee schedule.
- Health departments are losing Medicaid patient volume and revenue as Medicaid enrollment declines and more preventive services are provided by the recipient's "medical home."
- Anticipated preventive service business with partnerships has not materialized and revenues have declined accordingly.
- Demand for preventive services for the "medically homeless" (uninsured) has risen unexpectedly for public health and other providers as the percent of people without insurance rises.

All local health departments are facing these fiscal changes; however, the health departments participating in Medicaid partnerships are being impacted more rapidly and more severely.

The Cabinet for Health Services and the Department for Public Health have been working with the Department for Local Government, several local health department directors, and many county judge executives to determine the options available to us. We are determining the exact nature of the current fiscal situation and looking for ways to restructure to best adapt to the changes. My staff and I have initiated conversations between several local health department staff and their local physicians to determine what resources can be shared. We are also working to determine where it is possible to increase fees for environmental health services to enable those programs to be more self-sufficient.

Examples of the department's actions to date include:

- *Governor's Conference on the Future of Public Health in Kentucky* to define the issues
- *Kentucky Public Health Improvement Plan* to define the strategy for addressing the issues
- Define the core public health activities mandated by statute (all health departments)
- Define the cost of performing these core activities
- Define the personal preventive services available from health departments for the "medically homeless" (all health departments)
- Define the cost of performing these personal preventive services
- Define the home health nursing program benefit package (permitted but not mandated by budget or statute language)
- Define the cost of providing the home health benefit package
- Define the primary care benefit package (permitted but not mandated by budget or statute language)
- Coopers and Lybrand consultation on management, information, and business practice issues (1995-6)
- Develop a management tool to assist public health nurses and others make the transition from individual patient services to population-based services
- Schedule training sessions to instruct public health nurses and others to make the transition from individual patient services to population-based services
- Reorganize the Kentucky Department for Public Health to support population-based services
- Define requirements for an information system to support public health activities

- Create an information systems support branch within the department
- Purchase state of the art equipment for the state health department and selected local health departments
- Open and continuing communication with local health department directors, the county judges association, Kentucky Medical Association, and Interim Committee on Health and Welfare

District and county health departments along with their boards of health, medical communities, and elected officials are also being required to reassess their priorities in light of the inevitable decline in revenue. In situations like this organizations must look at ways to maximize productivity, share the load, reset priorities to ensure that critical mandated services are maintained, and look for additional sources of revenue. Each health department, board of health, and medical community needs to look into how K-CHIP and expanded Medicaid coverage for older children can get children into a medical home. Local health planning needs to identify what persons are among the "medically homeless" and decide how to use local resources to cover their needs. If there are still persons without service following this kind of assessment and restructuring, it will be appropriate to discuss additional funding. Local health departments in other states have had to undertake this effort as a result of similar pressures. It is reasonable to assume that we will have to do the same.

In addition, the Cabinet for Health Services is working on ideas to increase the availability of low cost insurance for persons without health insurance so they can find a "medical home" and we are working on ways to strengthen early childhood development in Kentucky.

Many of Kentucky's district and county health departments have already begun to rethink how they will serve their population in this new environment. Consider the following list of initiatives:

- Green River District Health Department—immunization registry and prenatal services
- Kentucky River District Health Department—prenatal care
- Cumberland Valley District Health Department—prenatal care and school health
- Barren River District Health Department—prenatal care, primary care
- Gateway District Health Department—dental health and nutritional services
- Lake Cumberland District Health Department—joint planning with hospitals, safety net planning for displaced garment workers
- Louisville-Jefferson County Health Department—birth and immunization registry
- Lincoln Trail District Health Department—prenatal services to private sector
- Jessamine County Health Department—general pregnancy prevention services
- Northern Kentucky Independent District Health Department—community-based planning, primary care
- Montgomery County Health Department—diabetes management
- Woodford County Health Department—transition planning for public health
- Knox-Whitley County Health Department—prenatal care and school health
- Madison County Health Department—prenatal services and school health
- Pike County Health Department—well child and prenatal care
- Lexington-Fayette County Health Department—prenatal relationships with University Hospital
- Franklin County Health Department—prenatal care
- Bullitt County Health Department—prenatal care and pregnancy prevention programs, smoking cessation for high school students

In summary, inevitable change is upon us and we must respond to the challenges and opportunities it presents. For over a generation, all of us in health care delivery have been able to deal with these issues on our own because someone found more money. In today's world, we can

no longer assume that more money will be forthcoming so we have to find ways to use what we have more productively by working together.

ACH Anecdotes

Community Partnership Recognized for Its Success:

We need to clone this kind of community development and put it all across the state.—Rice C. Leach, MD, Commissioner of the Department for Public Health

Enthusiastic, team-spirited, focused, productive, community-minded – these are just a few words that could be used to describe the Henderson County Diabetes Coalition. As the recipients of the Department for Public Health's (DPH) *Kentucky Diabetes Coalition Award*, this group was honored in October by a recognition reception for their outstanding diabetes-related contributions to their local community and to the Commonwealth. At the reception, both the national Centers for Disease Control and Prevention (CDC) and the state's public health commissioner, Rice Leach, MD, saluted coalition members. Dr. Leach said the Henderson coalition is "the kind of community development we need to clone and put across the state."

Back in 1996, a Green River District community-based assessment identified diabetes and its complications one of its top concerns. In addition, it was found that the western-most counties of the district represented the greatest need. As a result, the Green River District Health Department, under the direction of Lamone Mayfield, proceeded to focus in on this priority. Henderson County was selected as the smaller community to target because it serves as a link to the western counties in the district. With fiscal and technical support from the DPH's Adult Health Team of Janice Haile and Mary Linda Rogers, who organized and facilitated a more in-depth diabetes community-based assessment and planning process. The *Diabetes Today* model developed by the CDC was used for the effort. In the fall of 1996, the Henderson County Diabetes Coalition (HCDC) was formed as a result of this process.

In building and nurturing community partnerships many variables contribute to the outcome of such efforts. Some of the key factors contributing to the success of the HCDC include the following:

- Utilization of effective leadership
- Recruitment of the right people and organizations to participate
- Establishment of a clear focus
- Establishment of an efficient organizational structure
- Maintenance of an effective communication system
- Development & maintenance of a climate of mutual respect and value among members
- Establishment of a local identity
- Adequate resources
- Celebration of progress and successes

Effective leadership and facilitation skills have been very important and possibly the most crucial factor contributing to the success of the Henderson effort. The team of facilitators and the leaders who have emerged from the group have had the skills to establish an environment of acceptance, parity, shared responsibility, and credit for accomplishments as well as the skills to provide the needed structure and conflict resolution. In addition, Ms. Haile and Ms. Rogers were well suited for providing effective facilitation because of their years of experience in the community. Their known expertise, enthusiasm, and commitment, and the established trusted and respected relationships gave them added credibility in organizing this effort. There were benefits to using a tested model such as *Diabetes Today*. Primary too has been the ability to create vision and "sell" the group's purposes to members so effectively that others have wanted to become owners!

Probably the second most important factor in the success of the coalition is that the **appropriate individuals and organizations** became involved. The process began by organizing a core group of five agencies

invited to co-sponsor the project with the Green River District Health Department. This move also helped to extend the knowledge of the community beyond that of the facilitators. Together the core group began to organize their efforts, including the identification of other participants. They sought to recruit a broad-based representation of public and private-sector organizations as well as a cross section of key Henderson County citizens. The organizers recognized the benefits of seeking community leaders with diverse talents, abilities, and backgrounds. A combination of visionaries, mercenaries, and missionaries can provide a healthy, well-balanced organization. Recognizing the value of organizational representation, it was noted that many of the top organizational leaders may be "coalitioned to death" and not have the time nor interest to make an active commitment to the group. In these cases an attempt was made to identify an individual within an organization who had a strong interest and commitment to the issue as well as open communication with and the support of the main organizational leader. The core group also consciously sought to recruit individuals who represented multiple roles in the community. For example, one coalition member is an employee of the hospital in the business office, has good communication with the CEO, was recently diagnosed with type 2 diabetes through a community screening and is a key member of the local Lions Club. It has taken more than the initial search to tap into all the right people for HCDC. Recruitment has been an ongoing process to locate and retain a balanced mix of members.

Right from the beginning, the facilitators and core group clearly communicated the project purpose and participant expectations. As the planning process evolved and the group took shape, a **clear focus** developed. The facilitators led the group to clearly define its own purpose and roles. The coalition created a concisely written mission statement, and action plan with goals and measurable objectives, and by-laws with roles defined. The action plan is updated and revised annually. An agenda is prepared and used at every meeting by the president to keep the group focused and on target for wise use of time and resources.

Due to the time-consuming projects planned, the group gradually established an **organizational structure** to spread responsibility over the membership. Capable leadership developed from within to hold offices and to chair standing and ad hoc committees. With three levels of involvement—an executive group, standing committees, and general membership—the structure provides a fit for all levels of commitment. The group has worked to tap into the energy and talent of many so that they are able to take on multiple tasks and activities simultaneously with synergistic effects. Clear ground rules have been established in the by-laws, and the group has formed a non-profit corporation. Not only is this organizational structure efficient, but it provides stability and a better chance for survival when leadership changes.

A fifth factor that has contributed to the success of the Henderson County partnership is **effective communication**. Meeting minutes are distributed in a timely and consistent manner along with date reminders. This is vital to keeping individuals informed who may have missed a meeting and to verify understanding about who is to do what. Also, participants receive contact information for all members and are given an opportunity periodically to provide input on what is working well and suggestions for improvements. The coalition has also developed a method to orient and link new members into the group.

Through the leadership and membership, a climate of **mutual respect and value** has been established. Appreciation is shown for members' time and efforts so that no one is overextended. Perks have been built in with opportunities to recognize members for their hard work and contributions.

Another important factor in the success of the effort is that the group has developed a **local**

identity. Early in the process a coalition logo was created which has been used on letterhead, media messages, and all coalition-related business. Identifiers like the logo, coalition brochure, and media campaign have helped develop cohesion within the group as well as provided visibility, credibility, and information to the community. The *Diabetes Today Newsletter* has been an effective vehicle not only for establishing a coalition identity, but also for recognizing members, donors, sponsors, and volunteers; informing the community about coalition events; providing health education; helping with fund raising; and projecting an image of stability and professionalism. Ongoing media coverage has established a local identity for the coalition.

Adequate resources contributed greatly toward making the effort a priority and provided the means to organize and carry out an initial two full days of intensive assessment and planning. This meeting was held in a comfortable, neutral location and lunch was provided. The two-day retreat built on the group dynamics and the escalating excitement as the coalition looked at the scope of the problem of diabetes in Henderson County and worked through the problem-solving process step by step. During this time the individuals began to bond together and by the end of the session had jointly developed a plan of action.

In the two years of existence, the agencies represented in the coalition have provided resources for mailings, copying, hosting meetings, and co-sponsoring events. Additional resources have been secured by grant application, fund-raising activities, tapping into existing networks and by seeking cash or in-kind contributions from civic groups, businesses, diabetes product companies and individuals.

Finally, HCDC has evaluated progress and **celebrated achievements** with an annual birthday party. Media coverage has been used to highlight the group accomplishments and successes and to recognize individual and organizational contributions. When asked why members stay interested and active, some of the reasons given are commitment to the issue, evidence of progress, integration into work roles, exposure to new ideas, updated information, development of new skills, the satisfaction of a positive contribution to the community, socially enjoyable, and just plain FUN!

- submitted by Reita Jones, Division of Adult and Child Health

WORDS OF HEALTH FOR WOMEN

Who Are You Missing?

Can you identify your patients who are victims of domestic violence? Is it the teenager with a recurrent pregnancy? The woman who presents on a regular basis for pregnancy tests but is very inconsistent in her contraceptive use? The 30-year-old housewife who suffers from depression? The patient who you would rather that someone else see because she has a list of vague aches and pains every time she comes in the clinic?

Domestic violence is prevalent among women in their childbearing years. The highest rate occurs in heterosexual females between the ages of 16-24 and many times begins or escalates during pregnancy. This is the same age group that makes up the majority of women seen in our WIC, prenatal, and family planning clinics but because signs may be subtle, staff may fail to detect them unless **every** patient is screened for domestic violence.

Abuse may take place in many forms including slapping, hitting, threatening, humiliating, or criticizing.

Forced isolation, control of money, and coercive sexual activities are other forms of abuse. Abusive males typically seek control over their partner's behavior and sexuality including dictating their contraceptive method. Abused women may not even be able to negotiate condom use for STD protection.

Some common behavioral and psychological sequelae that may suggest a history of abuse are varied and may include teen pregnancy, poor contraceptive user, substance abuse , multiple sex partners, low self-esteem, depression, school failure, and previous suicide attempts or thoughts. Many of these women also experience eating disorders such as bulimia, anorexia, bingeing and purging, or chronic overeating with resulting obesity.

Women who are victims of domestic violence may present with numerous physical symptoms that include chronic headaches, chronic abdominal or pelvic pain, dyspareunia, chronic back pain, recurrent vaginitis, STDs, and gastrointestinal symptoms such as nausea, constipation, or diarrhea. How can you help women become more comfortable sharing their abuse with you? First, send out a signal that you know it is an all too common problem and you are willing to talk about it openly, offering her assistance and guidance. Victims of domestic violence don't "ask for it" or "get what they deserve" and health care providers should be very aware of their own feelings on this subject. The victim should never be told what they should do or be criticized for making a decision different than what the health care provider perceives as the "right thing to do."

Begin by screening all clients seen in clinics for domestic violence. We must be able to better identify the victims (or offenders) in order to offer counseling and referral. Questions on domestic violence are incorporated into the Adult Health Risk assessment tool (CH-94) with counseling tips noted in the new Public Health Practice Reference. Another brief but effectual screening tool is known by the acronym HITS.

- does he physically **H**urt her?
- **I**nsult or talk down to her?
- **T**hreatens harm to her or her children?
- **S**creams or curses at her?

Try putting up posters on domestic violence in the examination rooms and women's bathrooms that lists 1-800 hotline numbers for spouse abuse centers, crisis hotlines, etc. Always insist on time alone with your patient. If you have husbands, boyfriends, friends, or relatives who insist on staying with the patient during her entire visit, let it be known that it is a clinic policy for all patients to have some private time with the health care provider. Make sure your staff understands the magnitude of domestic violence, and always have community resources readily accessible and available for the patient to discreetly place in her coat or purse.

Many women are ashamed and afraid to admit they are a victim of abuse. It may take several visits to establish enough rapport before a patient can confide in the health care provider. Once abuse is identified, the first priority is to always address the patient's safety and the

safety of her children. Referral to mental health and legal options counseling are appropriate referrals. Reporting of abuse to the Department for Social Services (Community Based Services) is necessary and required by law for health care providers.

Domestic violence is a growing issue in health care and affects all races, ethnic groups, social classes and education levels. Unless we approach this "taboo" subject with acceptance, offering guidance and caring, then these victims of abuse will remain hidden, continue to suffer in silence, and perhaps never live their life to their fullest potential.

- *submitted by Trisha Mullins, Certified Nurse-Midwife, Women's Health Consultant*

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Central Office Comments

Public Health Aspects of Early Childhood Development: Remarks by Rice Leach, MD to the Cabinet for Health Services' Planning Retreat, February 2, 1999:

Since New Year's eve 1998, Kentucky's mothers have given birth to about 5,000 babies. Between now and the end of the year another 50,000 babies will join them. The Department for Public Health is charged with making sure that they, the 110,000 babies under age 3, the 185,000 in high school and other children grow and develop normally. All together, there are about 990,000 children under age 18 in Kentucky. All of them at one time or another experience early childhood development.

Fortunately, most of them were born with intact life support systems and required only that the world around them nurture their bodies, their minds, and their spirits. However, some of them were unfortunate. They arrived with birth defects like bad heart valves, cleft palates, blindness and deafness, cerebral palsy, low birth weight, spinal bifida, hyaline membrane disease of the lung, congenital hip, sickle cell anemia, and other conditions. Some of them had the misfortune to born to teenage mothers who are unprepared to care for them, to fathers who will not be around to help them grow, and to families that will neglect or abuse them. Some of them were born to mothers whose smoking caused their low birth weight. Some of them were born to mothers who neglected to take their vitamins and have spinal bifida. Some of them were born to mothers who abused drugs, had AIDS, syphilis, gonorrhea, and Chlamydia….diseases that will injure and kill some of them before they reach adulthood. Some of them were born to immigrant mothers who are increasingly unable to find acceptable prenatal and newborn care. Some of them were born to mothers whose obesity brought out diabetes and caused fetal distress. Some of them were born to hypertensive mothers whose bodies were unable to carry them to term.

Some of them were born into homes that have unsanitary waste and water systems. Some of them were born into families that will not use infant car seats or that have automobiles with leaky mufflers. Some of them were born into families whose homes don't have smoke detectors or other alarms to detect danger. Some of them were born into families that didn't want them to begin with and some of them never got here because their pregnancies were terminated as a result of fetal death, spontaneous abortion, or induced abortion.

Most of them will be fortunate. They will have adequate nutrition, their milk and food will be safe, and immunizations will protect them from diphtheria, polio, whooping cough, tetanus, measles, rubella, and hepatitis B. They will have adequate stimulation, adequate education, freedom from vaccine preventable disease, freedom from injury, and freedom from toxic exposure.

The Kentucky Department for Public Health and the local health departments across the

state perform a combination of public health protection, education, and preventive activities to ensure this. For 20 cents a day per Kentuckian they deliver the following services:

- ✓ birth certification & analysis
- ✓ death certification & analysis
- ✓ birth defects registry & analysis
- ✓ childhood death registry
- ✓ hospital discharge information & analysis
- ✓ certification of X-ray machines used on mothers and children
- ✓ enforcement of environmental health rules to reduce injury and illness
- ✓ tobacco control measures
- ✓ postponing sexual involvement programs
- ✓ injury research & prevention programs
- ✓ infant car seat programs
- ✓ farm safety programs
- ✓ certification of emergency service personnel & systems
- ✓ communicable disease control
- ✓ STD control
- ✓ product safety
- ✓ preventive children's health services
- ✓ regional pediatric programs
- ✓ immunizations
- ✓ school health
- ✓ newborn screening
- ✓ lead poison prevention
- ✓ KEIS
- ✓ dental health
- ✓ family planning
- ✓ prenatal care
- ✓ resource mothers
- ✓ nutrition counseling
- ✓ WIC food & counseling service
- ✓ EPSTD services
- ✓ children with special health care needs

and more.

As the meeting progressed, we shared some ideas for future development. One absolutely critical project that somehow missed the list is a health information system that will collect health information on children from their mother's family planning through conception, pregnancy, labor, and delivery and then through their own infancy, and preschool experience. Without these vital signs on the system one can never know what is going on with the children, especially those who move from one part of our fragmented health care system to another. We look forward to working with the other elements of the cabinet on this important initiative.

CORRECTION: Sexual Harassment Statement: In the January 1999 issue of the *Local Health Link*, it was stated that "In the near future, the Cabinet for Health Services hopes to issue a similar sexual harassment statement" as the one issued January 4, 1999 by the Cabinet for Families and Children.

Mr. Roger Smiley of DPH Personnel Office sent this correction: "Just wanted to let you know that CHS already has a Sexual Harassment statement. It is listed in the OPS Procedures manual and has been a part of employee orientation for over a year. In fact, CFC took ours and revised it with their cabinet name." Thanks Roger.

Lab Lines

Plasma Glucose Testing:
In response to the changes found in the new *Public Health Practice Reference*, the Division of Laboratory Services will begin plasma glucose testing for prenatal patients on March 1, 1999. To submit the specimens you will need the following supplies from our lab:

- Lab form 230, Clinical Chemistry (revised 11/23/98)
- Gray stoppered collection tubes (contains sodium fluoride preservative)
- Orange "Clinical Chemistry" shipping labels
- Double-can blood shipping system or the multi-mailer pack

Specimens may be shipped at room temperature. Specimens must be tested within five (5) days of collection.

Environmental Chemistry Reminders:

- Specimen collection kits for the *"Fluoride Test for Supplemental Program"* are sent to you by the Dental Health Program Office; please direct those requests to 502-564-3246.
- Blood lead screening tests are performed by the Jefferson County Health Department and specimens should be mailed directly to: Jefferson County Health Department, 400 East Gray

Street, Louisville, KY 40202.

- submitted by Donna Clinkenbeard, Division of Laboratory Services

PHPS Passages

Nutritional Value and Composition of Milk:
History records cows being milked as far back as 9000 BC. Cows did not arrive in Jamestown until 1611. Milk production was seasonal and the market was very local. Dairying changed very little until 1850. Pasteurization and refrigeration greatly enhanced the quality and distribution of milk and dairy products.

The Code of Federal Regulations, Title 21, Section 131.110 provides the following definition of milk:

> "Milk is the lacteal secretion, practically free from colostrum, obtained by the complete milking of one or more cows."

Milk and milk products provide 10% of the total available calories in the United States food supply and represent one of the best natural sources of essential amino acids for human nutrition.

Milk is composed of water, protein, fat, lactose, and minerals. Water normally makes up 84-90% of the total composition of milk; protein 3-4%; fat 2-6%; lactose and minerals 5-6%. The concentration of these components will vary between cows and breeds. Total milk solids refer to protein, fat, lactose, and minerals. Non-fat or "skim milk" contains milk solids minus fat. The economic value as well as the nutritional value of milk is directly associated with its solids content.

The production of quality milk and milk products begins on the farm and continues through handling, processing and distribution. Milk processing destroys human pathogens through pasteurization and attempts to maintain quality without loss of flavor and nutritive values. The finished product is protected from recontamination through careful handling, proper packaging and storage.

According to a draft of the *Healthy People 2010 Objectives*, the U.S. Department of Health and Human Services want to make sure Americans make calcium a part of their daily diet. Milk and milk food groups are a very important dietary source of calcium. Milk is also an excellent source of vitamin D, which is necessary for calcium absorption.

- submitted by Morris Strevels, Division of Public Health Protection and Safety

Staff Spotlight

A Healthy Outlook: Child Health Care Begins Long Before the Baby is Born:
Many times new or expectant mothers are unaware they are eligible for a world of services to help them with their newborn child.

And some of the most comprehensive and diverse of those programs are available through the Clark County Health Department.

Sandy Breeding, a registered nurse at the health department, said those who are expecting a child should first visit the department to check their eligibility, which is mainly determined by whether or not they have a medical assistance card.

If they have such a card, mothers typically begin their involvement with the health department through its Prenatal Services program.

As part of the program, the department will arrange and pay for many services relating to pregnancy, including nursing and nutrition counseling, medical visits at the department or a doctor's office if approved, routine lab tests and procedures, prenatal vitamins and medicine and the doctor's bill for a vaginal or C-section delivery.

Also covered in the program are the doctor's first examination of the baby after delivery and of the mother at 4-8 weeks after delivery and preapproved visits to specialists for pregnancy-related problems.

Mothers without medical cards also are eligible for nursing and nutrition counseling through the

program, as well as medical visits at the department, routine lab tests, their first ultrasound per physician's order and prenatal vitamins.

Services for those without medical cards are performed only with prior physician and hospital arrangements, Ms. Breeding said.

Further, if mothers are without insurance and are not eligible for a medical card, the department will provide prenatal care as long as the patient makes arrangements with a doctor to deliver the baby and a hospital where the delivery will occur.

After the child is born, mothers then can be eligible for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) through the department.

Through EPSDT, a child can receive a head-to-toe physical examination at certain times from birth through 21 years of age.

The importance of the exams is to determine if a child is born healthy without physical or mental problems, and as it grows, developing properly, Ms. Breeding said. The developmental screenings form the cornerstone of the department's Well Child Care program.

While a fee is required for all physical exams and screenings, payment is based on income, with maximum payments reaching no more that $40 per visit, she said.

The department also will inform all Clark County parents with medical cards of the EPSDT screening services that are available, she said.

Also chief among the programs offered by the department is Women, Infants and Children (WIC), one of the federal government's largest supplemental food programs.

Through the department, WIC provides nutrition counseling and vouchers for specific foods high in protein, iron and vitamin C to low-income pregnant women, new mothers, infants and children through age five (5).

With the vouchers, which are available only at the department, women can buy such food from authorized stores in the county.

Food items available with WIC vouchers include preapproved brands and types of milk and cheese, infant formula, juices, cereals, eggs, dried beans or peanut butter.

Women can be eligible for WIC if they have a medical card, receive food stamps, or if a pregnant woman or infant in a family has a medical card or receives other federal assistance.

By being involved in either WIC or the Prenatal Services program, mothers also can take advantage of the department's Enhanced Maternity Care program.

As part of that program, a registered nurse of the department will make one visit to a woman's home before she gives birth to her child and one visit within 24 hours after delivery. A follow-up visit also will be scheduled to come after the postpartum visit.

Following those visits, any specific medical problems detected can be referred back to the patient's physician.

Also, the nurse can provide the mother with counseling and education on nutrition, basic infant care and an opportunity to address any problems.

For a small fee, the department also will administer immunizations to children for all severe childhood diseases, with some of the vaccines beginning at birth and in the early months of life.

Through that program, the department will issue immunization certificates for schooling purposes and will network with local physicians to track immunization records for WIC participants.

As with most of the programs offered through the department, the available programs focus on preventative care rather than treatment of disorders, Ms. Breeding said.

When problems are detected, nearly all cases are referred back

to a patient's primary care physician for treatment, she said.

But no matter what, the programs are there to benefit the development and growth of all children involved, Ms. Breeding said.

"We like to make sure the parents are receiving these programs, using the programs, and make sure they are following through with the Well Child program," she said.

More information on infant or child-related programs may be obtained by calling the health department at 606-744-4482.
- excerpted from an article in The Winchester Sun, January 12, 1999 by Michael Cornett and submitted by Len Midden, Director, Clark County Health Department

Training Tidbits

RTC Training Courses – FY99
The Emory University Regional Training Center, Atlanta, GA, will provide fourteen (14) course offerings during fiscal year 1999 (July 1, 1998 – June 30, 1999). All fourteen (14) offerings along with registration and course content have been forwarded to District Training Contacts and LHD Administrators. Any LHD employee wishing to attend these offerings should contact their District Training Contact or LHD Administrator for course content and registration forms. Course dates, locations, and titles are listed below.

April 23, 1999 Louisville
- Assisting Clients To Change

April 30, 1999 Lexington
- HIV/AIDS Update

May 7, 1999 Frankfort
- Linking Quality Services *

May 14, 1999 Owensboro
- Orientation for New F.P. Nurses

May 14, 1999 Louisville
- Adolescent Health Issues

May 21, 1999 Lexington
- Creating An Efficient Clinic

June 4, 1999 Bowling Gr.
- Adolescent Health Issues

June 18, 1999 Morehead
- Postponing Sexual Involvement

June 24, 1999 Lexington
- Pharmacology Update for Clinicians

June 25, 1999 Lexington
- Current Reproductive Health Issues for Clinicians

*DISTANCE LEARNING EVENT – 4-5 Downlink sites

Domestic Violence Training for RN Licensure Requirements is being held at the following sites. Three (3) CEUs are provided to attendees.

Feb. 12, 1999 Hazard Community College

Feb. 17, 1999 Owenton

For registration, please contact Sandy Williams at 502-564-4990 or FAX at 502-564-2556.

Video / Audio Tapes ALERT:
If you have any outstanding video or audiotapes on loan for more than three weeks, please return them to me at the address given in the Editor's Note. Thank you for your cooperation.

EDITOR'S NOTE:
Please submit articles, staff spotlight nominees, or suggestions for the newsletter to:
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